MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Providence Memorial Hospital P.O. Box 809053 Dallas, TX 75380-9053	MDR Tracking No.: M4-03-8690-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Department of Transportation Box 32	Date of Injury: Employer's Name: Texas Department of Transportation Insurance Carrier's No.: 98240040

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
08/29/02	09/01/02	Inpatient Hospitalization	$59,090.66	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary not submitted.

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 08/01/03 written by Joel D. Wilk, M.D. states in part, "…The claimant is being billed $31112 for, if the summary sheet is correct, 2926 different implantables. The billing of the implantables is non-standard… No invoices are provided and no specifications, sole the one exception, as to the nature of the implants… Thee is nothing to suggest that usual, customary, and reasonable charges have been applied, which, for implantables, is manufacturer's invoice + 10%… In order for a hospital bill to be paid under stop-loss provisions, two criteria must be met. The first is that the hospital charges exceed 40K, which, for this claimant, appears to exist. The second criterion is that the hospitalization must be unusually costly or extensive. The claimant was admitted for a refusion of the lumbar spine. There is no documentation to suggest significant comorbidity facts in the billed charges. The claimant had two inpatient hospital days pre-authorized, and there is no documentation that pre-authorization was requested on the remaining inpatient day, as required by TWCC rules. Conclusion: This hospital bill does not meet both criteria for payment under stop-loss provision. Therefore, it should be using per diem methodology…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 3 days (consisting of 3 days for surgical); however, according to the preauthorization approval, preauthorization was given for 2 days. Accordingly, the standard per diem amount due for this admission is equal to $2,236.00 (2 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals); however, the healthcare provider did not provide the invoices. Therefore, MDR cannot confirm the cost plus 10% for the implantables or pharmaceuticals administered during the admission and greater than $250 per dose. The Requestor billed $81,768.88; the Carrier paid $2,236.00.

Considering the reimbursement amount calculated in accordance with the provisions of Rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Marguerite Foster	03/09/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____